

## OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Facilities Development Division 1600 9th Street, Room 420 Sacramento, CA 95814 (916) 654-3362 FAX (916) 654-2973



## **HOSPITAL INSPECTOR CERTIFICATION APPLICATION**

(Must be printed or typed)

EXAM APPLYING FOR: (Refer to Title 24, Part 1, Article 19, Section 7-204 (a), (b) & (c))  CLASS "A"  CLASS "B"  CLASS "C" - If applying for Class "C", fill in SPECIALITY  OSHPD HOSPITAL INSPECTOR CERTIFICATION #				PREFERRED TEST LOCATION:  LOS ANGELES SACRAMENTO AREA AREA			
NAME: MAILING ADDRESS:	LAST NUMBER			MI  Check if this is a change of address			
CONTACT:	CITY  ( )  TELEPHONE NUME	COUI	NTY  ( )  FAX (Optional)		STATE Z  E-MAIL ADDRESS	IIP CODE	
CANDIDATES WITH DISABILITIES OR SPECIAL REQUESTS: If you have a disability or special need that restricts your ability to take a test under standard conditions you may request special testing arrangements. Clarification of both the disability and the need for special accommodations by a licensed medical doctor is required.  Do you have a disability/impairment for which you may need assistance during the examination?  IF "YES", YOU WILL BE CONTACTED TO MAKE SPECIFIC ARRANGEMENTS.							
LIST CURRENT VALID LICENSES, CERTIFICATES AND MEMBERSHIPS IN PROFESSIONAL ASSOCIATIONS: (ATTACH COPIES)							
FORMERLY EMPLOYED BY OSHPD?							
CONSTRUCTIO	ON / INSPECTION	RELATED EDUCATION OR	SEMINARS ATTENDED:				
NAME AND LOCATION OF SCHOOL OR ORGANIZATION			COURSE OF STUDY		HOURS	DATE COMPLETED	
<b>EXPERIENCE:</b> BEGINNING WITH YOUR MOST RECENT POSITION, PROVIDE DETAILS OF YOUR EXPERIENCE WHICH QUALIFIES YOU FOR ENTRANCE TO THIS EXAMINATION. RESUMES WILL NOT BE ACCEPTED IN LIEU OF THE APPLICATION.							
LENGTH OF PRO	JECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V		NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:			
FROM:Y				FACILITY N	AME, BUILDING NAME	& PROJECT COST:	
HOURS WORKED PER WEEK:							
		✓ Verification letter attace	ched.				

## **EXPERIENCE CONTINUED:**

LENGTH OF PROJECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V	NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:		
FROM: TO:				
TOTAL: YR MO.		FACILITY NAME, BUILDING NAME & PROJECT COST:		
HOURS WORKED PER WEEK:				
	☐ Verification letter attached.			
LENGTH OF PROJECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V	NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:		
FROM: TO:				
TOTAL: YR MO.		FACILITY NAME, BUILDING NAME & PROJECT COST:		
HOURS WORKED PER WEEK:				
	✓ Verification letter attached.			
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FROM: TO:				
TOTAL:YR MO.		FACILITY NAME, BUILDING NAME & PROJECT COST:		
HOURS WORKED PER WEEK:				
	✓ Verification letter attached.			
LENGTH OF PROJECT ASSIGNMENT	Description of inspection duties performed for: Type(s) of Construction (Circle) I II III IV V	NAME, ADDRESS & PHONE NO. OF EMPLOYER/CLIENT:		
FROM: TO:				
TOTAL:YR MO.		FACILITY NAME, BUILDING NAME & PROJECT COST:		
HOURS WORKED PER WEEK:				
	✓ Verification letter attached.			
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FROM: TO:				
TOTAL: YR MO.		FACILITY NAME, BUILDING NAME & PROJECT COST:		
HOURS WORKED PER WEEK:				
	☐ Verification letter attached.			

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FROM: TO:			
TOTAL: YR MO.		<u>FACILITY</u>	NAME, BUILDING NAME & PROJECT COST:
HOURS WORKED PER WEEK:			
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FROM: TO:			
TOTAL: YR MO.		FACILITY	NAME, BUILDING NAME & PROJECT COST:
HOURS WORKED PER WEEK:			
	✓ Verification letter attached.		
application and any subsequent cer	made in this application are true and complete. I un rtification. I further certify that I will not reveal the co and that if I obtain OSHPD certification as a Hospita	ntents of the examina	ation to anyone and affirm that I will abide by the
(SIGNATURE)			(DATE)
FEE SCHEDULE	Check box for a fees subm	• •	OFFICE USE ONLY (DO NOT WRITE IN THIS)
SPACE)	1000 045		(55 (61 (11412 114 (1146)
Application Review (non-re			
Exam for Class A Inspector			
Exam for Class B Inspector			
Exam for Class C Inspecto		u	
METHOD OF PAYMENT	OTAL AMOUNT ENCLOSED \$		
	CHECK – PAYMENT MUST BE PAYABLE TO	D: OSHPD	
	RD AMERICAN EXPRESS NOVUS		dD.
	EXPIRATION.E		
PRINT CARD HOLDER'S NAME:	SIGNATURE:		-
			-
CITY:	STATE:ZIP CO	DE:	_
Mail payment and application	on to:		
Office of Statewide Health F Facilities Development Divi- Hospital Inspector Certifica 1600 9 <sup>th</sup> Street, Room 420,	sion tion Program		